State of Hawaii
Department of Transportation
Statewide Transportation Planning Office

2005

SECTION 5310
CAPITAL ASSISTANCE FOR THE TRANSPORTATION OF THE ELDERLY AND DISABLED

APPLICATION

In accordance to 49 USC Section 5310

Deadline to submit application is May 27, 2005

Please refer to the Application Instructions in the Information.

I. GENERAL INFORMATION

Name of Applicant Organization

Address

Organization Director and Title

Telephone _____

Fax _____

Email _____

Website _____

Type of Business (check one)

- ☐ Private Non-profit Organization
- ☐ Public Entity

Previous Section 5310 Recipient Organization (check one)

- ☐ Applicant Organization has received Section 5310 funds in the past. If yes, provide the last year the Section 5310 Project was awarded. _____
- ☐ Application Organization has never received Section 5310 funding.

Service Area (describe service area & check one)

- ☐ Population less than 200,000 – Non-Urbanized Area
- ☐ Population equal or greater than 200,000 – Urbanized Area

Services of Organization – **Elderly & Disabled Programs**

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – **Elderly & Disabled Programs**

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – **Elderly & Disabled Programs**

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – **Elderly & Disabled Programs**

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – **Elderly & Disabled Programs**

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – <u>Other Programs</u>

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – <u>Other Programs</u>

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – Other Programs

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – <u>Other Programs</u>

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

Services of Organization – <u>Other Programs</u>

Program Name _____

1. **Social, Health and/or Transportation Services Provided**

2. **Client Type & Characteristics**

3. **Days & Hours of Program Operation**

4. **Average Number of Clients Served by the Program per Month**

5. **Additional Information**

II. TRANSPORTATION INFORMATION

Ethnic Group

_____	White	_____	Vietnamese
_____	Hawaiian/Part Hawaiian	_____	Samoan
_____	Chinese	_____	Hispanic
_____	Japanese	_____	African American
_____	Filipino	_____	American Indian/Alaskan
_____	Korean	_____	_____

Gender

_____	Male	_____	Female

Driver Selection (check applicable)

- ☐ Verify driver credentials and records
- ☐ Physical examination
- ☐ Drug and alcohol testing
- ☐ Driver training
- ☐ Driver experience
- ☐ CDL
- ☐ _____

Driver Training (check applicable)

- ☐ Vehicle driving
- ☐ Vehicle use
- ☐ Vehicle equipment use, including ADA equipment
- ☐ Ambulatory client vehicle assistance
- ☐ Non-ambulatory client vehicle assistance
- ☐ Service program that transportation is provided for
- ☐ Vehicle pre- and post-trip check procedures
- ☐ Vehicle maintenance and repair procedures
- ☐ Vehicle accident procedures
- ☐ _____

Transportation Maintenance (check applicable)

- ☐ Employee(s) are assigned to provide for vehicle maintenance
- ☐ Vehicle regular maintenance policy
- ☐ Vehicle preventive maintenance policy
- ☐ Vehicle pre- and post-trip vehicle checklists
- ☐ Vehicle unscheduled maintenance policy
- ☐ _____

Repair & Maintenance

1. **Chassis Repair and Maintenance Service**

2. **Body Repair & Maintenance Service**

3. **Lift/Ramp/Gurney Equipment Repair & Maintenance Service**

Coordinated Transportation Services

Transportation Service Changes

Fleet Information – Complete the Fleet Information Table

Applicant Organization Name _____

II. TRANSPORTATION INFORMATION – Fleet Information Table										
Year	**Make**	**Model**	**License Plate #**	**VIN**	**Odometer Reading**	**Seating Capacity**	**W/C Lift or Ramp**	**# of W/C Tiedown**	**Program Names**	**5310 Yes/No**

Applicant Organization Name _____

II. TRANSPORTATION INFORMATION – Fleet Information Table										
Year	**Make**	**Model**	**License Plate #**	**VIN**	**Odometer Reading**	**Seating Capacity**	**W/C Lift or Ramp**	**# of W/C Tiedown**	**Program Names**	**5310 Yes/No**

Transportation Services

Program Name _____

1. Transportation Services & Operations Provided

2. Single Trips per Month

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

3. Transportation Service Type Percentage

Demand Responsive and/or Shuttle Service	**%**
Fixed Route	**%**
Total Percentage	**%**

4. Average Number of Clients Served by the Program per Month

5. Additional Information

Transportation Services

Program Name _____

1. Transportation Services & Operations Provided

2. Single Trips per Month

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

3. Transportation Service Type Percentage

Demand Responsive and/or Shuttle Service	**%**
Fixed Route	**%**
Total Percentage	**%**

4. Average Number of Clients Served by the Program per Month

5. Additional Information

Transportation Services

Program Name _____

1. Transportation Services & Operations Provided

2. Single Trips per Month

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

3. Transportation Service Type Percentage

Demand Responsive and/or Shuttle Service	**%**
Fixed Route	**%**
Total Percentage	**%**

4. Average Number of Clients Served by the Program per Month

5. Additional Information

Transportation Services

Program Name _____

1. Transportation Services & Operations Provided

2. Single Trips per Month

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

3. Transportation Service Type Percentage

Demand Responsive and/or Shuttle Service	**%**
Fixed Route	**%**
Total Percentage	**%**

4. Average Number of Clients Served by the Program per Month

5. Additional Information

Transportation Services

Program Name _____

1. Transportation Services & Operations Provided

2. Single Trips per Month

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

3. Transportation Service Type Percentage

Demand Responsive and/or Shuttle Service	**%**
Fixed Route	**%**
Total Percentage	**%**

4. Average Number of Clients Served by the Program per Month

5. Additional Information

III. PROJECT INFORMATION

Project Description (provide description, and submit draft specifications and plans)

Type of Project Use (check one)

☐ Replacement. Also, provide the license plate number of the proposed motor vehicle to be replaced.

_____

☐ Expansion

☐ New Service

Project Information

Program Name _____

1. Single Trips per Month with Proposed Project

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

2. Transportation Service Area

3. Transportation Service Benefits

4. Driver Characteristics

5. Client Assistance Provided

6. Passenger Fees or Fares per Single Trip

7. Additional Information

Project Information

Program Name _____

1. Single Trips per Month with Proposed Project

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

2. Transportation Service Area

3. Transportation Service Benefits

4. Driver Characteristics

5. Client Assistance Provided

6. Passenger Fees or Fares per Single Trip

7. Additional Information

Project Information

Program Name _____

1. Single Trips per Month with Proposed Project

Clients	Primary Use	Elderly disabled	
		Elderly non-disabled	
		Non-elderly disabled	
	Incidental Use	Non-elderly non-disabled	
Non-Clients	Incidental Use		

2. Transportation Service Area

3. Transportation Service Benefits

4. Driver Characteristics

5. Client Assistance Provided

6. Passenger Fees or Fares per Single Trip

7. Additional Information

Project Primary & Incidental Use (check one)

☐ Primary Use only

☐ Primary and Incidental Use. And, describe the Incidental Use and how it will not affect the Primary Use of the transportation of the elderly and/or disabled as described in the Application.

Project Cost Estimate

A. Total Project Cost Estimate	
B. Federal Funds Requested – maximum amount is 80% of A	
C. Applicant Organization Cost – A minus B	

Project Procurement (check one)

☐ The Department to procure project

☐ Agency other than the Department to procure project

Need for Project

Benefits of Project

Deficiencies if Project is Not Awarded

Project Equivalent Service (check one and if the 2nd is checked, provide information)

- ☐ The project proposed in the Application is accessible.
- ☐ The project proposed In the Application is non-accessible and Equivalent Service is provided. Provide the Equivalent Service policy and/or describe the Equivalent Service practice of the Applicant Organization.

Equipment Service Life

IV. FINANCIAL INFORMATION

Organization Income

Organization Expenses

Source of Share Cost

Transportation Operations & Maintenance Budget

REVENUES	Calendar Year			
	Past	Current	Next	2nd
Federal Funding Grants				
State Funding Grants				
Local Funding Grants				
Passenger Fees and Fares				
Donations				
Products or services income				
Fundraisers				
Total (A)				

EXPENSES	Calendar Year			
	Past	Current	Next	2nd
Driver				
Gas				
Regular & Preventive Maintenance				
Unscheduled Repairs				
Vehicle Insurance				
Indirect				
Total (B)				

NET BUDGET	Calendar Year			
	Past	Current	Next	2nd
(A) – (B)				

Transportation Operations & Maintenance– Revenue & Income Fluctuations

V. MANAGEMENT INFORMATION

Organization Structure

Number of Employees

_____ Full-time
_____ Part-time
_____ Volunteer
_____ Contract
_____ _____
_____ _____

Service Years

Organization has been in business for _____
Transportation services were provided for _____
Transporting the elderly or disabled was provided for _____

Transportation Experience

Transportation Human Resources

VI. LEGAL INFORMATION

Legal Resource (check one)

- ☐ The Applicant Organization has legal counsel
- ☐ The Applicant Organization does not have legal counsel

VII. OTHER FEDERAL REQUIREMENTS

Non-Duplication of Transportation Services (check one)

- ☐ Letters from public, private and para-transit operators within the Applicant Organization's transportation service area notifying the Hawaii State Department of Transportation indicating that their current and near future operations do not provide similar services proposed in the application.

- ☐ Efforts of notification to public, private and paratransit operators with similar transportation services within the Applicant Organization's transportation service area. Provide:

  - Copies of public notice in area newspapers with written comments from other transportation providers indicating that your current and near future transit services are not similar; and/or

  - Provide the date and name of transportation providers contacted indicating that your current and near future transit services are not similar.

Private Non-Profit Organizations (non-profit agencies only, check all)

- ☐ Copy of current Annual Domestic Non-Profit Corporation Exhibit or Non-Profit Status Letter from the Internal Revenue Service; and

- ☐ Copy of Incorporation Documentation

Public Entities (government agencies only)

☐ Signed letter by the Director of the Government Agency and the Mayor of the County certifying that no other public, private or para-transit operator is willing and able to provide the transportation service of the Applicant Organization.

Title VI of the Civil Rights Act of 1964 (check one)

☐ Completed and signed Title VI of the Civil Rights Act of 1964 assurance.

Nondiscrimination on the Basis of Handicap as Required by 49 CFR Part 27 (check one)

☐ Completed and signed Nondiscrimination on the Basis of Handicap as Required by 49 CFR Part 27 assurance.

VIII. CERTIFYING AUTHORITY

I am duly authorized to make the following certification on behalf of the Applicant Organization and based on my position, knowledge and experience with the Applicant Organization:

1) the information contained in the Application, including attachments, is true and correct;

2) the Applicant has the requisite fiscal, managerial, and legal capabilities to carry out the operations and maintenance of the Project in accordance with 40 U.S.C. Section 5310; and

3) the Applicant shall adhere to the federal, state and local requirements related to the Project.

Executed on _____ at _____
Date City/County and State

_____, _____
Signature Title